FOR OHF USE

LL I

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0037358

Facility Name: BRIDGEVIEW HEALTH CARE CENTER

Address: 8100 S. HARLEM AVE. (Number) BRIDGEVIEW (City) 60455 (Zip Code)

County: COOK

Telephone Number: (847) 679 - 8219 **Fax #** (847) 679 - 7377

IDPA ID Number: 36-3780344

Date of Initial License for Current Owners: 10/02/91

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[X]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2000 to 12/31/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) MARSHALL MAUER

(Title) TREASURER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)

(Print Name and Title) BOB KAGDA/PARTNER

(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD
3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124

(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

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Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	97	Skilled (SNF)	97	35,502	1
2		Skilled Pediatric (SNF/PED)			2
3	49	Intermediate (ICF)	49	17,934	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	146	TOTALS	146	53,436	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	6,506	5,054	2,179	13,739	8
9	SNF/PED					9
10	ICF	26,518	6,243	236	32,997	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	33,024	11,297	2,415	46,736	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.46%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/02/91

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/02/91 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 14 and days of care provided 1910

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Print Previe

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	178,842	28,691	6,252	213,785		213,785	0	213,785			1
2	Food Purchase		239,065		239,065	(34,733)	204,332	(6,726)	197,606			2
3	Housekeeping	100,330	35,955	0	136,285		136,285	0	136,285			3
4	Laundry	54,794	19,361	322	74,477		74,477	0	74,477			4
5	Heat and Other Utilities			82,973	82,973		82,973	664	83,637			5
6	Maintenance	73,786		33,526	107,312		107,312	6,241	113,553			6
7	Other (specify):*			6,302	6,302		6,302	556	6,858			7
8	TOTAL General Services	407,752	323,072	129,375	860,199	(34,733)	825,466	735	826,201			8
	B. Health Care and Programs											
9	Medical Director			2,100	2,100		2,100	0	2,100			9
10	Nursing and Medical Records	1,664,794	44,683	85,086	1,794,563		1,794,563	32,209	1,826,772			10
10a	Therapy	0	1,165	5,942	7,107		7,107	0	7,107			10a
11	Activities	118,458	12,011	1,932	132,401		132,401	0	132,401			11
12	Social Services	41,612		3,282	44,894		44,894	0	44,894			12
13	Nurse Aide Training			0				102	102			13
14	Program Transportation			0				0				14
15	Other (specify):*							2,883	2,883			15
16	TOTAL Health Care and Programs	1,824,864	57,859	98,342	1,981,065		1,981,065	35,194	2,016,259			16
	C. General Administration											
17	Administrative	62,304		153,618	215,922		215,922	(33,024)	182,898			17
18	Directors Fees			0				0				18
19	Professional Services			35,802	35,802	(261)	35,541	3,758	39,299			19
20	Dues, Fees, Subscriptions & Promotions			48,324	48,324	261	48,585	(29,019)	19,566			20
21	Clerical & General Office Expenses	108,711	19,157	190,477	318,345		318,345	(123,952)	194,393			21
22	Employee Benefits & Payroll Taxes			451,029	451,029	34,733	485,762	0	485,762			22
23	Inservice Training & Education			0				0				23
24	Travel and Seminar			5,168	5,168		5,168	537	5,705			24
25	Other Admin. Staff Transportation			6,066	6,066		6,066	25	6,091			25
26	Insurance-Prop.Liab.Malpractice			96,405	96,405		96,405	628	97,033			26
27	Other (specify):*			0				12,021	12,021			27
28	TOTAL General Administration	171,015	19,157	986,889	1,177,061	34,733	1,211,794	(169,026)	1,042,768			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,403,631	400,088	1,214,606	4,018,325		4,018,325	(133,097)	3,885,228			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Previe

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			32,252	32,252		32,252	157,445	189,697			30
31	Amortization of Pre-Op. & Org.							9,400	9,400			31
32	Interest			10,801	10,801		10,801	389,300	400,101			32
33	Real Estate Taxes			166,762	166,762		166,762	1,562	168,324			33
34	Rent-Facility & Grounds			543,000	543,000		543,000	(543,000)				34
35	Rent-Equipment & Vehicles			7,735	7,735		7,735	6,498	14,233			35
36	Other (specify):*							0				36
37	TOTAL Ownership			760,550	760,550		760,550	21,205	781,755			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers		30,454	69,381	99,835		99,835	(1,553)	98,282			39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			80,154	80,154		80,154	0	80,154			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers		30,454	149,535	179,989		179,989	(1,553)	178,436			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,403,631	430,542	2,124,691	4,958,864	0	4,958,864	(113,445)	4,845,419			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Print Previe

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals		2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients		10		7
8	Laundry for Non-Patients		4		8
9	Non-Straightline Depreciation	(3,008)	30		9
10	Interest and Other Investment Income	(1,344)	32		10
11	Discounts, Allowances, Rebates & Refunds	(5,518)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,208)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties		21		18
19	Entertainment	0	20		19
20	Contributions	(3,439)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(170)	19		22
23	Malpractice Insurance for Individuals		26		23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(26,251)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees		13		27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule DEFERRED MAINT XIX-H	(755)	6		29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (41,693)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(71,752)	SCHED	34
35	Other- Attach Schedule	0	ITTACHED	35
36	SUBTOTAL (B): (sum of lines 31-35)	$ (71,752)		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (113,445)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			$		47

Print Previe

Detail lines 29 and 35 of Page 9 starting in B44. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.

The amounts in the Adj. Summary column are linked to pages Summary A and B.

STATE OF ILLINOIS **Page 9A**

Facility Name **BRIDGEVIEW REHABILITATION CENTER**

IDH **0167210**

Report Period Beginning: **01/1/2008**

Ending: **12/31/2008**

NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference
The information listed in B13 thru G65 is from Page 5.		
1 **Day Care**	0	0
2 **Other Care for Outpatients**	0	0
3 **Governmental Sponsored Special Programs**	0	0
4 **Non-Patient Meals**	0	2
5 **Telephone, TV & Radio in Resident Rooms**	0	0
6 **Rented Facility Space**	0	34
7 **Sale of Supplies to Non-Patients**	0	10
8 **Laundry for Non-Patients**	0	4
9 **Non-Straight-line Depreciation**	(3,008)	30
10 **Interest and Other Investment Income**	(1,344)	32
11 **Discounts, Allowances, Rebates & Refunds**	(5,518)	2
12 **Non-Working Officer's or Owner's Salary**	0	0
13 **Sales Tax**	(1,288)	2
14 **Non-Care Related Interest**	0	32
15 **Non-Care Related Owner's Transactions**	0	0
16 **Personal Expenses (Including Transportation)**	0	25
17 **Non-Care Related Fees**	0	20
18 **Fines and Penalties**	0	21
19 **Entertainment**	0	20
20 **Contributions**	(3,439)	20
21 **Owner or Key Man Insurance**	0	22
22 **Special Legal Fees & Legal Retainers**	(170)	19
23 **Malpractice Insurance for Individuals**	0	26
24 **Bad Debt**	0	27
25 **Entertaining, Advertising and Promotional**	(26,251)	20
26 **Income & IL Personal Property Replacement Taxes**	0	0
27 **Nurse Aide Training for Non-Employees**	0	13
28 **Yellow Page Advertising**	0	20
29 **Non-Paid Workers**	0	0
30 **Donated Goods**	0	0
31 **Amortization Expense**	0	0
32 DEFERRED MAINTENANCE	(755)	6
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To Print the Other Adjustments you have entered.

1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

Print Other Adjustment

Sch V	Adj. Summary
Line 1	0
Line 2	(6,756)
Line 3	0
Line 4	0
Line 5	0
Line 6	(334)
Line 7	0
Line 8	(4,446)
Line 9	0
Line 10	0
Line 10a	0
Line 11	0
Line 12	0
Line 13	0
Line 14	0
Line 15	0
Line 16	0
Line 17	0
Line 18	(170)
Line 19	(1,170)
Line 20	(29,690)
Line 21	0
Line 22	0
Line 23	0
Line 24	0
Line 25	0
Line 26	0
Line 27	0
Line 28	(755)
Line 29	(51,814)
Line 30	(10,000)
Line 31	0
Line 32	(1,344)
Line 33	0
Line 34	0
Line 35	0
Line 36	0
Line 37	(4,452)
Line 38	0
Line 39	0
Line 40	0
Line 41	0
Line 42	0
Line 43	0
Line 44	0
Line 45	(41,814)

Reference 1	Reference 2	Reference 3	Reference 4	Reference 5	Reference 6	Reference 7	Reference 9	Reference 10	Reference 10a	Reference 11	Reference 12	Reference 13	Reference 14	Reference 15	Reference 17	Reference 18	Reference 19	Reference 20	Reference 21	Reference 22	Reference 23	Reference 24	Reference 25	Reference 26	Reference 27	Reference 30	Reference 31	Reference 32	Reference 33	Reference 34	Reference 35	Reference 36	Reference 38	Reference 39	Reference 40	Reference 41	Reference 42	Reference 43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary A

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(6,726)	0	0	0	0	0	0	0	0	0	0	(6,726)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	664	0	0	0	0	0	0	0	0	664	5
6	Maintenance	(755)	0	3,392	3,604	0	0	0	0	0	0	0	6,241	6
7	Other (specify):*	0	0	96	0	460	0	0	0	0	0	0	556	7
8	**TOTAL General Services**	(7,481)	0	4,152	3,604	460	0	0	0	0	0	0	735	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	32,209	0	0	0	0	0	0	0	32,209	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	102	0	0	0	0	0	0	0	0	102	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	2,883	0	0	0	0	0	0	2,883	15
16	**TOTAL Health Care and Programs**	0	0	102	32,209	2,883	0	0	0	0	0	0	35,194	16
	C. General Administration													
17	Administrative	0	(153,618)	0	120,594	0	0	0	0	0	0	0	(33,024)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(170)	2,325	1,603	0	0	0	0	0	0	0	0	3,758	19
20	Fees, Subscriptions & Promotions	(29,690)	0	671	0	0	0	0	0	0	0	0	(29,019)	20
21	Clerical & General Office Expenses	0	(167,430)	40,104	3,374	0	0	0	0	0	0	0	(123,952)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	537	0	0	0	0	0	0	0	0	537	24
25	Other Admin. Staff Transportation	0	0	25	0	0	0	0	0	0	0	0	25	25
26	Insurance-Prop.Liab.Malpractice	0	0	628	0	0	0	0	0	0	0	0	628	26
27	Other (specify):*	0	0	5,316	0	6,705	0	0	0	0	0	0	12,021	27
28	**TOTAL General Administration**	(29,860)	(318,723)	48,884	123,968	6,705	0	0	0	0	0	0	(169,026)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(37,341)	(318,723)	53,138	159,781	10,048	0	0	0	0	0	0	(133,097)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(3,008)	157,676	2,777	0	0	0	0	0	0	0	0	157,445	30
31	Amortization of Pre-Op. & Org.	0	9,400	0	0	0	0	0	0	0	0	0	9,400	31
32	Interest	(1,344)	388,637	2,007	0	0	0	0	0	0	0	0	389,300	32
33	Real Estate Taxes	0	0	1,562	0	0	0	0	0	0	0	0	1,562	33
34	Rent-Facility & Grounds	0	(543,000)	0	0	0	0	0	0	0	0	0	(543,000)	34
35	Rent-Equipment & Vehicles	0	0	6,498	0	0	0	0	0	0	0	0	6,498	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(4,352)	12,713	12,844	0	0	0	0	0	0	0	0	21,205	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	(1,553)	0	0	0	0	0	(1,553)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	(1,553)	0	0	0	0	0	(1,553)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(41,693)	(306,010)	65,982	159,781	10,048	(1,553)	0	0	0	0	0	(113,445)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT
FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Page 6

Facility Name & ID Number: BRIDGEVIEW HEALTH CARE CENTE — # 0037358 — Report Period Beginning: 01/01/2000 — Ending: 12/31/2000

VII. RELATED PARTIES

Show Pgs 6A thru 6 | Show Pgs 6E thru 6 | Hide Pgs 6A thru 6

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHI		SCHEDULE ATTACHED		SCHEDULE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	Line	2 3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference; Adjustments for Related Organization Costs (7 minus 6)		Sum_6
1	V	21 MANAGEMENT FEES	152,428	DYNAMIC HEALTHCARE CONSULTANT		$	$ (152,428)	1	-152618
2	V	21 BOOKKEEPING FEES	167,430	"			(167,430)	2	-167430
3	V			"				3	0
4	V			"				4	0
5	V			"				5	0
6	V			"				6	0
7	V			"				7	0
8	V			"				8	0
9	V	25 RENT	543,000	BRIDGEVIEW ASSOCIATE			(543,000)	9	-543000
10	V	20 DEPRECIATION		"		157,676	157,676	10	157676
11	V	23 AMORTIZATION		"		9,400	9,400	11	9400
12	V	21 MANAGEMENT FEES		"		388,637	388,637	12	388637
13	V	21 ACCOUNTING FEES		"		2,325	2,325	13	2325
14	Total		862,858			$ 558,038	$ * (304,818)	14	

* Total must agree with the amount recorded on line 30 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

Print Previe

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line 1 Line 2 Line 3 Line 4 Line 5 Line 6 Line 7 Line 9 Line 10 Line 10a Line 11 Line 12 Line 13 Line 14 Line 15 Line 17 Line 18 Line 19 Line 20 Line 21 Line 22 Line 23 Line 24 Line 25 Line 26 Line 27 Line 30 Line 31 Line 32 Line 33 Line 34 Line 35 Line 36 Line 38 Line 39 Line 40 Line 41 Line 42 Line 43

Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6A
15	V	5	UTILITIES	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 664	$ 664	15	664
16	V	6	REPAIRS & MAINT.		" " "	100.00%	3,392	3,392	16	3392
17	V	7	EMP. BEN. - GEN. SERVICES		" " "	100.00%	96	96	17	96
18	V	13	NURSES AIDE TRAINING		" " "	100.00%	102	102	18	102
19	V	19	PROFESSIONAL FEES		" " "	100.00%	1,603	1,603	19	1603
20	V	20	DUES AND SUBSCRIPTION		" " "	100.00%	671	671	20	671
21	V	21	CLERICAL & GENERAL		" " "	100.00%	40,104	40,104	21	40104
22	V	24	SEMINARS AND TRAVEL		" " "	100.00%	537	537	22	537
23	V	25	ADMIN. STAFF TRANS		" " "	100.00%	25	25	23	25
24	V	26	INSURANCE		" " "	100.00%	628	628	24	628
25	V	27	EMP BEN. - GEN ADMIN.		" " "	100.00%	5,316	5,316	25	5316
26	V	30	DEPRECIATION		" " "	100.00%	2,777	2,777	26	2777
27	V	32	INTEREST		" " "	100.00%	2,007	2,007	27	2007
28	V	33	REAL ESTATE TAXES		" " "	100.00%	1,562	1,562	28	1562
29	V	35	EQUIPMENT RENTAL		" " "	100.00%	6,498	6,498	29	6498
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$			$ 65,982	$ * 65,982	39	

* Total must agree with the amount recorded on line 34 of Schedule VI.

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Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6B
15	V	6	MAINT. CMP. - D. NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 3,604	$ 3,604	15	3604
16	V	10	NURSING CMP - SUE G.		" " "	100.00%	32,209	32,209	16	32209
17	V	17	ADMIN. CMP. - M. MAUER		" " "	100.00%	29,092	29,092	17	29092
18	V	17	ADMIN. CMP. - M. AARON		" " "	100.00%	37,219	37,219	18	37219
19	V	17	ADMIN. CMP. - F. AARON		" " "	100.00%			19	
20	V	17	ADMIN. CMP. - A. STERN		" " "	100.00%	23,457	23,457	20	23457
21	V	17	ADMIN. CMP. - S. GOLDSTEIN		" " "	100.00%			21	
22	V	17	ADMIN. CMP. - S. KOPLIN		" " "	100.00%			22	
23	V	17	ADMIN. CMP. - D. MAGAFAS		" " "	100.00%	7,700	7,700	23	7700
24	V	17	ADMIN. CMP. - E. CASSON		" " "	100.00%			24	
25	V	17	ADMIN. CMP. - S. BOGEN		" " "	100.00%			25	
26	V	17	ADMIN. CMP. - S. LEVY		" " "	100.00%	8,470	8,470	26	8470
27	V	17	ADMIN. CMP. - A. STEINER		" " "	100.00%	2,767	2,767	27	2767
28	V	17	ADMIN. CMP. - NON-OWNER		" " "	100.00%	11,889	11,889	28	11889
29	V	21	CLERICAL CMP. - S. AARON		" " "	100.00%	3,374	3,374	29	3374
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$			$ 159,781	$ * 159,781	39	

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Previe

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Print Page 6

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Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6C
15	V	7	EMP. BEN. - D. NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 460	$ 460	15	460
16	V	15	EMP. BEN. - SUE G.		" " "	100.00%	2,883	2,883	16	2883
17	V	27	EMP. BEN. - M. MAUER		" " "	100.00%	813	813	17	813
18	V	27	EMP. BEN. - M. AARON		" " "	100.00%	944	944	18	944
19	V	27	EMP. BEN. - F. AARON		" " "	100.00%			19	
20	V	27	EMP. BEN. - S. GOLDSTEIN		" " "	100.00%			20	
21	V	27	EMP. BEN. - S. KOPLIN		" " "	100.00%			21	
22	V	27	EMP. BEN. - D. MAGAFAS		" " "	100.00%	1,267	1,267	22	1267
23	V	27	EMP. BEN. - E. CASSON		" " "	100.00%			23	
24	V	27	EMP. BEN. - S. BOGEN		" " "	100.00%			24	
25	V	27	EMP. BEN. - S. LEVY		" " "	100.00%	1,161	1,161	25	1161
26	V	27	EMP. BEN. - A. STEINER		" " "	100.00%	459	459	26	459
27	V	27	EMP. BEN. - NON-OWNER		" " "	100.00%	1,599	1,599	27	1599
28	V	27	EMP. BEN. - S. AARON		" " "	100.00%	462	462	28	462
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$			$ 10,048	$ * 10,048	39	

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Previe

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4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
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Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10a	THERAPY	$ 5,941	DYNAMIC REHAB CONSULTANTS LLC		$ 5,941	$	15
16	V	22	EMPLOYEE BENEFITS		" " "				16
17	V	39	ANCILLARY SERVICES	61,039	" " "		61,039		17
18	V								18
19	V								19
20	V	10	NURSING & MEDICAL SUPP	8,146	PHARMCOR LLC		8,146		20
21	V	11	ACTIVITIES		" "				21
22	V	22	EMPLOYEE BENEFITS		" "				22
23	V	39	ANCILLARY EXPENSE	22,893	" "		22,893		23
24	V								24
25	V								25
26	V	20	DUES, FEES & SUBSCRIPTION		LINCOLN MEDICAL SUPPLIES, INC.				26
27	V	10	MEDICAL SUPPLIES		" " "				27
28	V	39	ANCILLARY EXPENSE	5,903	" " "		4,350	(1,553)	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 103,922			$ 102,369	$ * (1,553)	39

Sum_6D

-1553

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Previe

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Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ABE STERN		ADMINISTRATIVE			SCHEDULE	ATTACHED	CONSULTA	$ 23,457	17-7	1
2	MARSHALL MAUER		ADMINISTRATIVE					SALARY	29,092	17-7	2
3	MAURY AARON		ADMINISTRATIVE					SALARY	37,219	17-7	3
4	SHARON AARON		CLERICAL					SALARY	3,374	21-7	4
5				SCHEDULE							5
6				ATTACHED							6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 93,142		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Print Previe

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2000 Ending: 2/31/2000

VIII. ALLOCATION OF INDIRECT COSTS [Show Pgs 8A thru 8] [Show Pgs 8E thru 8] [Hide Pgs 8A thru 8]

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679 - 8219
Fax Number: (847) 679 - 7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	TOTAL PATIENT DAYS	707,726	15	$ 10,055	$	46,736	$ 664	1
2	6	REPAIRS & MAINT	" "	707,726	15	51,362	16,071	46,736	3,392	2
3	7	EMP. BEN. - GEN. SVC.	" "	707,726	15	1,448		46,736	96	3
4	13	NURSES AIDE TRAINING	" "	707,726	15	1,550		46,736	102	4
5	19	PROFESSIONAL FEES	" "	707,726	15	24,272		46,736	1,603	5
6	20	DUES & SUBSCRIPTIONS	" "	707,726	15	10,163		46,736	671	6
7	21	CLERICAL & GENERAL	" "	707,726	15	607,305	465,093	46,736	40,104	7
8	24	SEMINARS & TRAVEL	" "	707,726	15	8,134		46,736	537	8
9	25	ADMIN. STAFF TRANS.	" "	707,726	15	372		46,736	25	9
10	26	INSURANCE	" "	707,726	15	9,517		46,736	628	10
11	27	EMP.BEN. - GEN. ADMIN.	" "	707,726	15	80,498		46,736	5,316	11
12	30	DEPRECIATION	" "	707,726	15	42,057		46,736	2,777	12
13	32	INTEREST	" "	707,726	15	30,386		46,736	2,007	13
14	33	REAL ESTATE TAXES	" "	707,726	15	23,654		46,736	1,562	14
15	35	EQUIPMENT RENTAL	" "	707,726	15	98,401		46,736	6,498	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 999,174	$ 481,164		$ 65,982	25

Print Previe

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STATE OF ILLINOIS

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679 - 8219
Fax Number: (847) 679 - 7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINT. CMP. - D. NEHMER	WGHTD. AVG. HOURS	40	14	$ 54,000	$ 54,000	3	$ 3,604	1
2	10	NURSING - SUE G	" "	40	1	32,209	32,209	40	32,209	2
3	17	ADMIN. CMP. - M. MAUER	" "	40	14	435,842	435,842	3	29,092	3
4	17	ADMIN. CMP. - M. AARON	" "	45	14	558,156	558,156	3	37,219	4
5	17	ADMIN. CMP. - F. AARON	" "	50	7	160,040	160,040		0	5
6	17	ADMIN. CMP. - A. STERN	" "	8	14	351,664		1	23,457	6
7	17	ADMIN. CMP. - S. GOLDSTEIN	" "	50	3	179,079	179,079		0	7
8	17	ADMIN. CMP. - S. KOPLIN	" "	45	10	67,732	67,732		0	8
9	17	ADMIN. CMP. - D. MAGAFAS	" "	45	10	82,127	82,127	4	7,700	9
10	17	ADMIN. CMP. - E. CASSON	" "	45	2	47,882	47,882		0	10
11	17	ADMIN. CMP. - S. BOGEN	" "	45	3	119,320	119,320		0	11
12	17	ADMIN. CMP. - S. LEVY	" "	55	14	126,974	126,974	4	8,470	12
13	17	ADMIN. CMP. - A. STEINER	" "	45	14	41,511	41,511	3	2,767	13
14	17	ADMIN. CMP. - NON-OWNER	" "	45	14	178,292	178,292	3	11,889	14
15	21	CLERICAL CMP. - S. AARON	" "	40	14	50,548	50,548	3	3,374	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,485,376	$ 2,133,712		$ 159,781	25

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STATE OF ILLINOIS

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679 - 8219
Fax Number: (847) 679 - 7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	7	EMP BEN - D. NEHMER	WGHTD. AVG. HOURS	40	14	$ 6,887	$	3	$ 460	1
2	15	EMP BEN - SUE G.	" "	40	1	2,883		40	2,883	2
3	27	EMP BEN - M. MAUER	" "	40	14	12,175		3	813	3
4	27	EMP BEN - M. AARON	" "	45	14	14,155		3	944	4
5	27	EMP BEN - F. AARON	" "	50	7	19,744			0	5
6	27	EMP BEN - S. GOLDSTEIN	" "	50	3	18,514			0	6
7	27	EMP BEN - S. KOPLIN	" "	45	10	14,423			0	7
8	27	EMP BEN - D. MAGAFAS	" "	45	10	13,516		4	1,267	8
9	27	EMP BEN - E. CASSON	" "	45	2	10,284			0	9
10	27	EMP.BEN. - S. BOGEN	" "	45	3	7,029			0	10
11	27	EMP BEN - S. LEVY	" "	55	14	17,400		4	1,161	11
12	27	EMP BEN - A. STEINER	" "	45	14	6,891		3	459	12
13	27	EMP BEN - NON-OWNER	" "	45	14	23,984		3	1,599	13
14	27	EMP BEN - S. AARON	" "	40	14	6,917		3	462	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 174,802	$		$ 10,048	25

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STATE OF ILLINOIS

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC REHAB CONSULTANTS LLC
Street Address: 3359 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679 - 8219
Fax Number: (847) 679 - 7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		DYNAMIC REHAB CONSULTANTS				$	$		$	1
2	10a	THERAPY	DIRECT ALLOCATION						5,941	2
3	22	EMPLOYEE BENEFITS	" "							3
4	39	ANCILLARY SERVICES	" "						61,039	4
5										5
6										6
7		PHARCOR LLC								7
8	10	NURSING & MEDICAL SUPPLY	DIRECT ALLOCATION						8,146	8
9	22	EMPLOYEE BENEFIT	" "							9
10	39	ANCILLARY EXPENSE	" "						22,893	10
11										11
12										12
13		LINCOLN MEDICAL SUPPLIES								13
14	20	DUES, FEES & SUBSCRIPTION	DIRECT ALLOCATION							14
15	10	MEDICAL SUPPLIES	" "							15
16	39	ANCILLARY EXPENSE	" "						4,350	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 102,369	25

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Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PHARMOR, LLC.
Street Address: 3116 S. OAK PARK
City / State / Zip Code: BERWYN, IL 60402
Phone Number: (847) 795 - 7701
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
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17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

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Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	LASALLE BANK		X	MORTGAGE	$45,250.00	06/30/95	$ 5,250,000	$ 4,555,307	06/30/05	8.4	$ 388,637	1
2												2
3												3
4												4
5												5
	Working Capital											
6	LASALLE BANK		X	WORKING CAPITAL				60,000		PRIME+	10,801	6
7												7
8	RELATED PARTIES	X									2,007	8
9	TOTAL Facility Related				$45,250.00		$ 5,250,000	$ 4,615,307			$ 401,445	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,250,000	$ 4,615,307			$ 401,445	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	180,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	170,762	2
3. Under or (over) accrual (line 2 minus line 1).	$	(9,238)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	176,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	166,762	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	167,299	8
	1996	169,230	9
	1997	171,966	10
	1998	175,735	11
	1999	170,762	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 1999 TAX YEAR.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**

This denial must be no more than four years old at the time the cost report is filed.

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Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,560 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 4

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 0 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: 0 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME			$ 304,000	1
2					2
3	TOTALS			$ 304,000	3

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12 | Show Pgs 12C and 12 | Hide Pgs 12A thru 12

STATE OF ILLINOIS

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	146		1995		$ 5,092,000	$ 130,559	39	$ 130,559	$	$ 798,075	4
5											5
6											6
7											7
8					28,901	751	35	837	86	6,138	8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	LEASEHOLD IMPROVEMENTS			1991	1,017	32	31.5	32		295	9
10	LEASEHOLD IMPROVEMENTS			1991	2,715	181	15	181		1,667	10
11	LEASEHOLD IMPROVEMENTS			1992	85,574	2,718	31.5	2,718		24,237	11
12	LEASEHOLD IMPROVEMENTS			1993	1,600	51	31.5	51		393	12
13	LEASEHOLD IMPROVEMENTS			1994	8,141	209	39	209		1,362	13
14	IST FLOOR CENTRAL A/C			1995	1,250	32	39	32		169	14
15	CARPET INSTALL			1995	1,303	33	39	33		172	15
16	RAIL BUMPER			1995	917	24	39	24		121	16
17	INSTALL PRESSURE CONTROL, LOCK & ALARM			1996	5,320	136	39	136		629	17
18	PAINTING WORK			1996	8,400	215	39	215		941	18
19	WALL COVERING			1996	1,435	37	39	37		159	19
20	FRONT LOBBY/WINDOW,DOOR WORK			1997	2,509	65	39	65		220	20
21	ELEVATOR REPAIR			1998	2,800	72	39	72		207	21
22	CONDENCING UNIT			1999	3,824	98	39	98		162	22
23	DRAPES			1999	5,369	138	39	138		192	23
24	CARPETING AND VINYL FLOORING			1999	8,540	219	39	219		324	24
25	DOOR WORK			1999	10,490	269	39	269		361	25
26	KITCHEN CABINETS			1999	5,832	150	39	150		219	26
27	TILES			2000	8,855	136	27.5	136		136	27
28	ELEVATOR REPAIR			2000	4,240	66	27.5	66		66	28
29	ROD MAIN SEWER			2000	1,100	18	27.5	18		18	29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 136,209		$ 136,295	$ 86	$ 836,263	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2

**Improvement type must be detailed in order for the cost report to be considered complete

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
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34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

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Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 204,243	$ 26,084	$ 20,426	$ (5,658)	10 YRS	$ 98,790	37
38	Current Year Purchases	9,466	1,471	947	(524)	10 YRS	947	38
39	Fully Depreciated Assets							39
40	RELATED PARTY	321,171	28,941	32,029	3,088	10 YRS	179,596	40
41	TOTALS	$ 534,880	$ 56,496	$ 53,402	$ (3,094)		$ 279,333	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	NURSING, HSKPG, MAINT	1991 DODGE VAN	1991	$ 24,971	$	$	$	4 YRS	$ 24,971	42
43										43
44										44
45										45
46	TOTALS			$ 24,971	$	$	$		$ 24,971	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 192,705	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 189,697	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (3,008)	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,140,567	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

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Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 3,770 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMINISTRATOR	2000 GMC JIMMY	$ 489.00	$ 7,068	17
18	PAYROLL DEDUCTION			(3,103)	18
19					19
20					20
21	TOTAL		$ 489.00	$ 3,965	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY TRAINED AIDES.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

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Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 23,891	$		$ 23,891	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			2,167			2,167	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			34,983			34,983	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				23,481		23,481	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	39 2&3				8,340	6,973		15,313	13
14	TOTAL			$		$ 69,381	$ 30,454		$ 99,835	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

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Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 396,976	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	572,176		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	37,689		6
7	Other Prepaid Expenses	2,769		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,009,610	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	171,225		15
16	Equipment, at Historical Cost	238,680		16
17	Accumulated Depreciation (book methods)	(212,815)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(8,995)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DEPOSITS	508,995		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 697,090	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,706,700	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 146,605	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	60,000		29
30	Accrued Salaries Payable	261,693		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,273		31
32	Accrued Real Estate Taxes(Sch.IX-B)	176,000		32
33	Accrued Interest Payable	48		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Management Fees	76,933		36
37	Due to Others	82,513		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 814,065	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 814,065	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 892,635	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,706,700	$	48

***(See instructions.)**

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Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 763,521	1
2	Restatements (describe):		2
3	**IL REPLACEMENT TAX**	(713)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 762,808	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	129,827	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 129,827	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 892,635	24 *

*** This must agree with page 17, line 47.**

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Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,044,010	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,044,010	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	37,819	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 37,819	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,344	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,344	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DISCOUNTS	5,518	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,518	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,088,691	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 860,199	31
32	Health Care	1,981,065	32
33	General Administration	1,177,061	33
	B. Capital Expense		
34	Ownership	760,550	34
	C. Ancillary Expense		
35	Special Cost Centers	99,835	35
36	Provider Participation Fee	80,154	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,958,864	40
41	**Income before Income Taxes (line 30 minus line 40)****	129,827	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 129,827	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,841	2,155	$ 60,761	$ 28.20	1
2	Assistant Director of Nursing	1,833	2,124	54,678	25.74	2
3	Registered Nurses	12,312	13,854	260,285	18.79	3
4	Licensed Practical Nurses	21,677	25,553	439,249	17.19	4
5	Nurse Aides & Orderlies	73,751	85,578	712,426	8.32	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,353	2,644	36,394	13.76	9
10	Activity Assistants	9,962	11,123	82,064	7.38	10
11	Social Service Workers	3,332	3,847	41,612	10.82	11
12	Dietician	2,855	3,308	41,203	12.46	12
13	Food Service Supervisor					13
14	Head Cook	5,045	5,690	45,822	8.05	14
15	Cook Helpers/Assistants	14,280	15,324	91,817	5.99	15
16	Dishwashers					16
17	Maintenance Workers	4,824	5,249	73,786	14.06	17
18	Housekeepers	14,986	16,029	100,330	6.26	18
19	Laundry	7,366	8,084	54,794	6.78	19
20	Administrator	2,049	2,358	62,304	26.42	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,237	9,377	108,711	11.59	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,814	4,300	74,581	17.34	31
32	Other Health Care(specify)					32
33	Other(specify)	3,676	4,322	62,814	14.53	33
34	TOTAL (lines 1 - 33)	194,193	220,919	$ 2,403,631 *	$ 10.88	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	262	$ 6,252	1-3	35
36	Medical Director	42	2,100	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	96	1,927	10-3	39
40	Physical Therapy Consultant	136	4,743	10a-3	40
41	Occupational Therapy Consultant	19	674	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	15	525	10a-3	43
44	Activity Consultant	44	1,932	11-3	44
45	Social Service Consultant	68	3,282	12-3	45
46	Other(specify)				46
47	PSYCHIATRIC	10	440	10-3	47
48					48
49	TOTAL (lines 35 - 48)	692	$ 21,875		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses	23	463	10-3	51
52	Nurse Aides	4,681	82,256	10-3	52
53	TOTAL (lines 50 - 52)	4,704	$ 82,719		53

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Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MARTHA PECK	ADMIN	0.00%	$ 62,304
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 62,304

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 153,618
TOTAL (agree to Schedule V, line 17, col. 3)	$ 153,618
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
HEALTH DATA SYSTEM	DATA PROCESSING	$ 2,564
IL COLLECTION SERVICES	COLLECTION	170
KRUPNICK, BOKOR	ACCOUNTING	16,869
BURKE, WARREN, MACKAY	LEGAL	204
SACHNOFF, WEAVER	LEGAL	8,240
PERSONNEL PLANNERS	UC CONSULTANT	912
COX LTD	LIFE SAFETY CODE	464
ISP/DYNAMIC HEALTHCARE	BACKGROUND CHECK	231
ECONOCARE	PURCHASING CONSLT	2,700
JOHN J CLARKE	BACKGROUND CHECK	30
FINKEL MARTWICK COLSON	LEGAL	3,418
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 35,802

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 55,511
Unemployment Compensation Insurance	17,514
FICA Taxes	183,865
Employee Health Insurance	186,108
Employee Meals	34,733
Illinois Municipal Retirement Fund (IMRF)*	
PENSION/PROFIT SHARING CONTRIB	0
EMPLOYEE BENEFITS-OTHER	8,031
EMPLOYEE PHYSICAL EXAMS	0
INSURANCE EXECUTIVE LIFE	0
CHICAGO HEAD TAX	0
RELATED PARTY	0
INSURANCE EXECUTIVE LIFE	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 485,762

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	10,188
Health Care Worker Background Check	261
(Indicate # of checks performed 26)	
ADV & PROMO/MARKETING	26,251
DUES & SUBSCRIPTIONS	6,506
LICENSES & PERMITS	1,940
TRUST FEES, CONTRIBUTIONS,etc.	3,439
MGMT CO ALLOCATION	671
LESS TRUST FEES, CONTRIB, etc.	(3,439)
Less: Public Relations Expense	( )
Non-allowable advertising	(26,251)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,566

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL	0
RELATED PARTY	537
Seminar Expense	5,168
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,705

* Attach copy of IMRF notifications

**See instructions.

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Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	PAINT/DECORATINC	1996	$ 2,152	5	$ 430	$ 430	$ 430	$ 430	$ 217	$	$	$	$
2	PAINT/DECORATINC	1999	4,058	3			676	1,353	1,353	676			
3	PAINT/DECORATINC	2000	3,046	3				508	1,015	1,015	508		
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 9,256		$ 430	$ 430	$ 1,106	$ 2,291	$ 2,585	$ 1,691	$ 508	$	$

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Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE 4,891**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **YES** If YES, have these costs
been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **9,948** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **80,154**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **NO** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **34,733** Has any meal income been offset against
related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **NO** If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned for providing such
transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.